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David Morales
Commissioner
Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116-4704

Re: Proposed Regulations: 114.5 CMR 21.00 Health Care Payer Claims Data Submission, Appendix A - Data and File Specifications and 114.5 CMR 22.00: Health Care Claims Data Release, Appendix A: Restricted Data Release Elements

Dear Mr. Morales:

Thank you for the opportunity to provide testimony on proposed Regulations 114.5 CMR 21.00 Health Care Payer Claims Data Submission, and its Appendix A - Data and File Specifications.

The Massachusetts Department of Public Health (MDPH) enthusiastically supports the collection of these data and the creation of an All Payer Claims Database (APCD) for the Commonwealth.

This written testimony will provide an overview of why this regulation is so crucial for improving the public's health in Massachusetts; it will discuss how MDPH plans to use the information generated pursuant to this regulation and give specific examples, and it will close with some suggestions for how MDPH can help support this effort.

The APCD is essential in four key ways. First, it will be an invaluable resource for MDPH and the Commonwealth to improve our understanding of morbidity and the use of services in MA; second it will fill gaps with data not currently available; third, cost savings will be achieved not only through more efficiently identifying high risk populations but also by eliminating the submission of duplicative data; and fourth, it will enhance our ability to monitor the health outcomes related to health care reform. The priority for Health Care Reform so far has been on getting persons covered; these data will allow us to examine use of services such as preventive care, ambulatory treatment, and medication use in the context of existing MDPH health outcomes data such as cancer incidence, treatment for substance abuse, delivery of timely trauma

care, assessment of work-place injuries and illness, adverse maternal and perinatal outcomes, tobacco, diabetes, asthma and cardiovascular disease prevention efforts, and a variety of longer-term measurable health outcomes that may be related to expanded access through health care reform

UNIQUE IMPORTANCE OF ALL PAYER CLAIMS DATABASE TO MDPH

As mentioned, MDPH considers the creation of the All Payer Claims Database (APCD) to be a very exciting and important achievement towards fulfilling the missions of both our agencies. MDPH will specifically benefit from additional population-based prevalence estimates, more precise geographic and health equity analysis, coordination with existing public health surveillance sources and other unique analyses due to the availability of new data such as non-reportable diseases, pharmaceutical utilization and direct costs of services. However, the APCD's greatest legacy may come from how it could dramatically alter the analyses conducted by public health programs to develop, evaluate and report on the impact they have on their targeted, and oftentimes underserved, communities. This impact could also include direct cost savings and cost benefit analysis as a result of specific program interventions. In general, the data included in the APCD will address crucial surveillance and monitoring gaps that exist across Bureaus and Programs within the Department.

CRITICAL VARIABLES TO BE INCLUDED IN THE APCD

MDPH feels strongly that specific critical variables should be included in the APCD in order to fully realize the many potential uses described in this written testimony. They include:

1. Detailed geographic identifiers that enable geocoding and neighborhood analyses. These identifiers are crucial for examining small area variation in the use of health services and outcomes, will enable more precise program targeting, and are essential for investigating potential environmentally related disease clusters
2. Unique identifiers across payers, databases and years are needed to more fully understand the breadth of services and outcomes for individuals and their families
3. Inclusion of complete, consistent and accurate race/ethnicity data; development of socioeconomic status measures (i.e., educational achievement, household income); and assessment of disability status in order to focus on disparities and special population needs
4. Work-related claims to examine occupational health issues; and
5. Explicit pharmacy data to provide an integrated approach to understanding the health consequences of medication use combined with the delivery of clinical services.

ANALYTIC EXAMPLES AND PROGRAMMATIC IMPACT

The MDPH will use APCD data for at least 6 purposes:

- estimating prevalence of disease/condition
- assessing standards of care for disease/condition
- examining the financial impact of disease/condition
- performing trend analysis
- evaluating program impacts
- analyzing health disparities

Provided below are some specific examples of how MDPH will use the data; this list is not meant to be comprehensive, and will grow as the department becomes more familiar with these data.

The Bureau of Substance Abuse Services (BSAS)

As BSAS continues to better understand the treatment need for Substance Use Disorders, utilization and cost within the Commonwealth, it is continually confounded by two fundamental gaps in treatment data - both of which could be substantially filled with the integration of medical claims data. As the single state authority for substance abuse, BSAS collects substance abuse treatment administrative data for all licensed and contracted provider organizations. However, for many treatment types, BSAS is a minority payer creating significant gaps in collected service data. At the same time, the Bureau has little understanding of medical services delivered to those with substance use disorders resulting in a significant gap in data to understand the total utilization, cost and health outcomes of treatment and related services.

Specifically, the availability of an All Payer Claims database will significantly enhance the Bureau's ability to:

- Monitor and evaluate the need for treatment services including improved service planning and resource allocation.
- Monitor and evaluate the changes over time in treatment utilization and, in particular, identify over/under utilization of treatment programs regardless of payer.
- Construct complete episodes of care for those with Substance Use Disorders.
- Evaluate the total cost of treatment at a system, program and individual level per member per month.
- Identify and evaluate cross-system level measures of performance and utilization allowing the Bureau to identify opportunities to implement strategies to reduce overall system cost while improving outcomes.
- Effectively monitor and evaluate the impact of and respond to large policy and practice changes including *Health Care Reform* and the *National Substance Abuse Parity Project*

The Division of Research and Epidemiology, Bureau of Health Statistics (DRE) will:

- Supplement existing surveillance reports with expanded measures of morbidity using claims, pharmacy, and product file data. Current surveillance reports focus on outcomes such as mortality, self-reported illness, hospitalization, and cancer incidence. Reports include the MDPH Regional Health Reports, Health of Massachusetts, and disease-specific reports. Using the APCD data will assist us in more fully understanding the spectrum of population-based illness in the Commonwealth.
- Expand focus on disparities research: the Division is currently a major focal point for MDPH disparities research. These data will help expand our ability to examine race and ethnicity variation in the use of health services.
- Enhance existing perinatal research studies. For example, one project examining the impact of fertility assistance on maternal and infant outcomes would greatly benefit from

the use of pharmacy and claims procedure data to examine the use of infertility medications and procedures.

- Discuss the possibility of including fully de-identified aggregate community level APCD information in MassCHIP, which is the MDPH free online web-based data query system provides health data to the public, community-based organizations, policy makers, and state health programs at the community level. This would greatly enhance the availability of public health related data and move us decisively towards increasing transparency of state government data accessibility. **Of course, all data release would strictly adhere to data release standards required by DHCFP.**

The Bureau of Health Care Safety and Quality will:

- Develop an integrated unique patient tracking identifier across multiple sites of service and episodes of care to facilitate monitoring gaps in continuity of care, identifying referral patterns, and assessing available primary care networks (including patient centered medical homes) for mitigating preventable emergency department visits and rehospitalizations .
- Extract rehabilitation claims to create a third tier linkable dataset to enhance clinical content in DPH's existing trauma, cardiac, and stroke registries to develop more robust quality of care indicators to monitor functional outcome and to identify deficits in rehabilitation care. This would include all sites of rehabilitation care not captured in existing state databases, including skilled nursing facilities, long-term acute care facilities, and rehabilitation hospitals.
- Enhance the Bureau's Pharmacy Monitoring Program (PMP) data using the finer gradient of demographic data on an insurance member's race, ethnicity and language and detailed information on coinsurance amounts, deductible amounts, dispensing fees, and ingredient cost/list price found in the APCD pharmacy files. HCQ will use pharmacy claims data to identify demographic trends in prescription and pharmaceutical treatment patterns associated with specific diseases, and to identify potential sources of abuse and less than optimal resource use; assess any associations between unintentional overdose/medical complications by pharmaceutical treatment patterns and assess regional, demographic and provider patterns in overuse of pharmacy services, enhance monitoring of patients on long-term medications (ACE inhibitors, digoxin, diuretics, anticonvulsants) and assess yearly follow-up to monitor such patients by site of primary care and provider of care.
- Use pharmacy claims data for targeted monitoring of the quality of primary care and nursing home medication management in the elderly, identify inappropriate prescription patterns, preventable adverse effects and the association of such effects with preexisting conditions such as the interaction between chronic renal failure and NSAIDs use , bleeding related to inappropriate warfarin management.
- Evaluate clinical service provided in nursing facilities, outpatient rehabilitation facilities, hemodialysis centers, primary care clinics and freestanding ambulatory surgery and imaging centers.
- Identify disparities by income, race, and payer in core quality of care measures such as access to hemodialysis, routine primary care access, short stay and long stay nursing home patients who develop pressure sores by patient level demographics not available in the current Federal Nursing Home Compare Tools
- Assess patterns in overuse of free standing imaging services

- Evaluate the quality and patterns in access to therapeutic tissue, organ and cadaver donations by disease type and continuity of care and the rehabilitation of such product recipients.
- Analyze geographic differences in outpatient free standing surgical resource availability by episodes of care, by claims patterns (public and private), eligibility differences, intensity of use, economic status, and follow-up time span between utilization and any onset of hospitalized complications.
- Compare the medical necessity, beneficiary level, outcome, complications, comorbidities and quality care provided in freestanding ambulatory surgery centers with comparable surgery provided at other inpatient hospital settings to determine appropriateness of care.
- Create quality measures to evaluate access to and the quality of follow-up care after hospitalization and to help with setting priorities for improving the continuum of care.
- Compare nursing home quality and safety outcomes in homes with higher percentages of racial and ethnic minorities versus other nursing homes.

The MDPH Tobacco Control and Prevention Program (MTCP) will:

- Assess the impact of tobacco cessation pharmacy use on medical conditions and costs
- Determine the percentage of insurance plan members who use a tobacco cessation pharmacy drug such as the nicotine patch, nicotine gum, lozenge, Chantix, and bupropion (Zyban)
- For children of smokers, to report whether conditions such as asthma have been impacted by use of pharmacotherapy
- Calculate the health care costs of smoking by family
- Assess the impact of tobacco control policies on specific medical conditions (e.g., smoke-free laws and tax increases)
- Calculate the health care costs of smoking (SAMMEC model) by other appropriate groups

The Diabetes Prevention and Control Program (DPCP) will:

- More precisely estimate the prevalence of diabetes for population under 18 years of age
- Evaluate the implementation of guidelines for diabetes care (Adult Type 2, Youth and Adolescents Type 2, Gestational Diabetes) such as compliance with medications, preventive services and continuity of care
- Assess the impact of hemodialysis use by people with diabetes
- Analyze potential cost savings from improving chronic disease management
- Calculate an estimate for needle use (from insulin) from pharmacy claims to address environmental issue with disposal of medical waste

The Heart and Stroke Prevention and Control Program (HSPC) will:

- Link stroke registry discharges to 30 day outcomes
- Monitor medication adherence for
    - High blood pressure, high cholesterol medication claims (fills, refills) and

    - Anti-coagulants, anti-thrombotics, et al associated with CVD diagnoses
- Evaluate chronic disease management and referrals associated with CVD comorbidities (i.e. diabetes education)
- Use medical claims data to validate 30 day outcomes
- Calculate quantifiable costs/cost-savings as a result of lowering or elimination of health disparities
- Use the CDC high blood pressure and high cholesterol indicators in evaluating relevant programmatic efforts

The Bureau of Environmental Health (BEH) will:

- Supplement current community health investigations of outcomes involving health and environmental exposure concerns and/or emergency events
- Tighten the Lead / asthma program evaluation efforts
- Expand the spectrum of health outcomes available for the development of disease registries and surveillance systems
- Provide a secondary data source for other surveillance systems, such as the Massachusetts amyotrophic lateral sclerosis registry, where completeness of case ascertainment could be assessed
- Identify geographic location of exposure, as represented by street address as well as small geographic areas such as census blocks and census tracts

The Asthma Prevention and Control Program (APCP) will:

- Link medication use to acute care facility use by asthma sufferers which will provide more in-depth analysis of asthma and also help us better target our public health interventions.
- Compare quality of care to identify health disparities in asthma control by race, geography, age and other variations in asthma outcomes.

The Occupational Health Surveillance Program (OHSP) will:

- Gather population-based surveillance information about work-related injuries and illnesses.
- Perform case-based surveillance for work-related conditions which are reportable to the Department of Public Health; providers and/or hospitals of any cases identified as work-related will be contacted to obtain medical records in order to follow-up with the patient.
- Link the APCD to the hospital databases and/or workers' compensation database to calculate rates by industry and race/ethnicity

The Division of Violence and Injury Prevention will:

- Be able to examine the full impact of the burden and the true financial costs of injuries through the addition of outpatient claims data.
- Examine health care utilization and outcomes after serious injury (post-hospitalization).
- Examine prescription patterns for osteoporosis treatment medication and the association with fall-related fractures.
- Examine prescription patterns for anticoagulants and the association of the use of these drugs to traumatic brain injuries.
- Examine the prevalence of health services such as vision exams, bone density screenings, fall risk assessments, and physical therapy, and the association of these health services with subsequent injury.

The Nutrition, Physical Activity and Obesity Program will:

- Develop measures around the burden of obesity on health care costs through availability of medical and/or pharmacy claims data including bariatric surgery, reimburseable weight loss programs, weight loss medications and other data not previously available

MAINTAINING PRIVACY OF PERSONAL HEALTH CARE INFORMATION

In conclusion MDPH realizes that the APCD data can have a huge impact on improving the health of the Commonwealth. However, like the Division, MDPH realizes the primacy of protection of the privacy rights of those about whom these data are collected. We pledge to continue to work with the Division of Health Care, Finance & Policy (DHCFP) to establish the necessary steps in order to preserve these rights. The APCD, because of its shear size and the nature of the information it contains, will require MDPH and DHCFP cooperation to ensure the appropriate use of these data while guaranteeing the legal protection for this information.

We look forward to this collaborative effort to use the APCD to substantially improve the health of the residents of Massachusetts.

Sincerely,

Bruce Cohen, Ph.D
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Massachusetts Department of Public Health